MEDICAL ASSISTANCE IN DYING IN CANADA: ETHICAL, POLICY, AND CLINICAL CONSIDERATIONS

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Abstract

This paper is an examination of the current Medical Assistance in Dying (MAiD) law in Canada and the various perspectives on this policy. This paper also examines the current state of knowledge and research conducted on this legislation in North America and Europe. `Clinical practice and ethical issues will also be explored from the perspectives of both social workers and physicians. The current state of palliative care in Canada and the services and supports available at end-of-life will be discussed. Alternatives to MAiD such as palliative sedation are examined. The debate over whether to extend access to vulnerable populations such as individuals living with a disability or using advance directives will also be analyzed. This paper will explore social work perspectives on MAiD and on end-of-life care issues and identify gaps and areas for future research. Additionally, the paper provides a list of recommendations based on current issues identified within the research.

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Introduction

Four years ago, the Supreme Court of Canada ruled that patients were no longer required to live with intolerable suffering from their illnesses and could ask for medical assistance to end their lives (Beuthin, Bruce, & Scaia, 2018). Medical Assistance in Dying (MAiD) refers to a physician or nurse practitioner assisting an individual at their own request to end their life (Health Canada, 2019). The medical assisted dying law was created to respect patient autonomy, to relieve suffering, and as an option to support patients that are facing a crisis (Sulmasy, Mueller, Snyder, Sulmasy, & Ethics, 2017). A recent report from Health Canada (2019) found that cancer is the most common underlying condition, accounting for 65 percent of all medically assisted deaths in Canada. The current law requires that patients are over the age of 18, have a grievous and irremediable condition, make a voluntary request that is not the result of external pressures, and that other alternatives are offered by the assessors prior to a patient being approved to complete MAiD (BCCSW, 2017). In contrast to other assisted dying laws, Canadians are not required to have a terminal illness, but that an individual's death is reasonably foreseeable (Downie & Scallion, 2018).

Health Canada outlines two forms of MAiD that include a clinician-assisted procedure where providers directly administer the medication that causes death, or a self-administered medication is provided to patients by an eligible physician or Naturopathic Doctor (Beuthin et al, 2018). A recent report from 2018 found that nearly 7000 Canadians chose to have the intervention (Health Canada, 2019). According to recent stats both the number of patients being assessed for MAiD and those choosing to have the provision is increasing each year (Health Canada, 2019). Despite the new legislation that allows patients the right to ask for help to end their lives, many patients are still facing barriers to get there (Carter, Rodgerson, & Grace, 2018).

Under current federal legislation, many individuals do not qualify for the intervention and may end up having to suffer unnecessarily due to the strict and ambiguous criteria that has been set out (Carter & Rodgerson, 2018).

MAiD is an extremely controversial practice because it goes against a health care system that promotes curing and caring (Carter et al, 2018). For instance, Wu et al (2018) argues that physicians are trained to save lives and not end them. Trying to balance the competing values of the rights of patients with those of the medical profession has been a challenging endeavor (Wu et al, 2018). MAiD has also created tensions between religious organizations that often fund faith-based institutions and care homes because it goes against their values and beliefs (Gardner & Lowis, 2014). Current provincial exemptions allow these institutions to refuse to allow MAiD on their premises (Carter et al, 2018). An alternative solution to MAiD that has been identified within the literature is increasing funding for palliative care (Gardner & Lowis, 2014). On the other hand, supporters claim that it is a social justice issue and that individuals should have the right to relieve their suffering and chose a 'dignified death' (Carter et al, 2018). With the current law to be reviewed by 2021, I feel that it is determinantal to address the concerns with the current law. This paper will look at the clinical, ethical and practice implications in MAiD.

This paper will be guided by an anti-oppressive practice approach to the research that considers the social justice issues that arise from this policy. Burke and Harrison (2002) define anti-oppressive practice (AOP) as "a dynamic process based on the changing complex patterns of social relations" (p.132). This approach looks at the use of abuse of power among individuals, organizational behaviors, and within the broader social structures (Burke & Harrison, 2002). In using an anti-oppressive approach, social workers must develop a perspective that is flexible, is theoretically informed, challenges existing ideas, includes the views of oppressed individuals,

has multidimensional change strategies, and involves continuous self-reflection and evaluation (Burke & Harrison, 2002). Burke and Harrison argue that this approach requires that social workers go beyond the descriptions of the nature of oppression to come up with creative and dynamic ways of challenging inequality and disadvantage. Danso (2015) describes AOP as a framework to understand how differences are used to oppress people and how to transform society. AOP also commits to promoting social justice by addressing the various systems of oppression and unequal power relations (Danso, 2015). Social justice within social work can be conceptualized as "an ideal condition in which all members of a society have the same basic rights, protections, opportunities, obligations, and social benefits" (NASW, 2012, as cited in Morgaine, 2014 p. 5). This paper will employ a social justice lens while investigating and evaluating the current policies and practices.

There are many gaps in the current research such as the Canadian experiences of MAiD. Furthermore, current literature often focuses on the role of physicians, and not on other health care professionals that are involved such as nurses and clinical social workers. This paper will explore both social work and physician perspectives on MAiD and on end-of-life care. The literature review will also explore contributions of the social work field to this topic area, as well as areas for future research to advance our knowledge. The goal of the paper is to find out what research has been conducted and the current state of knowledge on this issue. The knowledge reviewed will include a variety of perspectives and themes that are in disagreement or contradictory of each other.

Considerable controversy exists among both the medical community and society as to whether MAiD is ethically and morally permissible (Allan & Allan, 2020). Moreover, policymakers in Canada are considering expanding the current criteria for MAiD to include

vulnerable populations such as mature minors, individuals living with a disability, or to those that have lost the cognitive capacity to consent. For instance, the current law does not allow advance requests for MAiD to be carried out in the event that the individual has lost the ability to consent (Allan & Allan, 2020). This paper will explore the various positions on this policy and will provide recommendations based on current issues identified within the research. The terms MAiD, medically assisted dying, and assisted dying will also be used interchangeably throughout the paper as the term "MAiD" is a Canadian term and other countries have adopted different terminology for medically assisted dying. The purpose of the paper is to present current thinking and foster more discussion on this issue and how the current policy has been implemented in Canada.

Research Questions:

1. What are the ethical considerations that challenge the provision of MAiD?
2. How does the ambiguity around the criteria for MAiD impact physicians that are often required to make personal judgements?
3. How does this policy impact patients with no access to palliative care?
4. Does MAiD directly conflict with the philosophy of palliative and hospice care?
5. Should MAiD be extended to include vulnerable populations such as mature minors, individuals living with cognitive impairments or mental illness, or those that have lost the cognitive capacity to consent?

Methodology

This paper will explore research conducted on MAiD with a major emphasis on research conducted within the last 5-7 years. This paper will utilize data from throughout the world, with a major focus on North American research. European research will be included as medically assisted dying was legalized much earlier than in North America and European countries such as Belgium and the Netherlands have made a substantial contribution to this area of research. A thematic review of the literature will be provided using specific search terms. The key search terms that are used in this paper are as follows: assisted dying laws; assisted dying and ethics; assisted suicide; attitudes towards disability; patients' rights; bioethics, right to die, hospice care; physicians; and advance directives. The research database that will be utilized in this paper is the "Academic Search Complete" database on the University of Fraser Valley's library website. This paper will also utilize google internet searches to find additional peer reviewed research articles and government documents.

The research used in this paper will be selected based on the quality of the research. The quality will be determined based on if it has been peer-reviewed and published in a reputable journal or government resource. This paper will also ensure that the information is credible by investigating the authors background and experience in the field. Furthermore, this paper will focus on recent research, and will only include relevant older articles. In addition, this paper will explore whether the research is supported within the field by other experts. This paper will also critically evaluate the study's research design, sample size, data analysis, criteria and criteria measures, ethics, and whether limitations of the study are mentioned. This paper will reference from the British Columbia College of Social Workers (BCCSW), The Canadian Association of Social Workers (CASW) and the National Association of Social Workers (NASW) that is based

out of the United States. Currently the CASW and NASW have a collaborative partnership as they share common objectives, have similar values and ethics, as well work together to advance social work in both North America and worldwide (NASW, 2012). In terms of advancing social work research and practice within this area it may also be useful to look at the various codes and how they have addressed MAiD.

Ethical Considerations in MAiD:

Ethical Arguments Supporting MAiD

Research examining the ethical issues related to MAiD has increased significantly over the last decade. The research shows that many patients may consider MAiD because they experience intense physical, psychological and interpersonal suffering during end-of-life and may find some comfort in being able to control the timing of their death (Snyder, Sulmasy, & Mueller, 2017). One of the most cited ethical principles in support of allowing MAiD for patients is the ethical principle of autonomy (Allan & Allan, 2020). Autonomy is considered to be one of the most fundamental principles within both medical ethics and western culture (Allan & Allan, 2020). Snyder et al (2017) state that proponents of MAiD view the intervention as an act of compassion that respects a patients' right to make their own health care decisions, as well as "fulfills an obligation of nonabandonment" (p.577). Another key fundamental ethical principle within medical ethics is compassion. Allan and Allen (2020) acknowledge that health care providers have a duty to relieve suffering. For example, many patients fear the symptoms that often accompany the end stages of illness and they may wish to end their lives to avoid those symptoms that are part of the reality of their illness (Allan & Allan, 2020). For many patients, receiving MAiD before these symptoms occur can be viewed as an act of compassion by health care providers (Allan & Allan, 2020).

The ethical principle of social justice is also relevant to MAiD (Westefeld et al, 2013). This ethical principle views that all individuals have equal access to care, and that treatment is delivered in an equal and just manner (Westefeld et al, 2013). Treatment must also be delivered in a way that minimizes one's own biases and personal judgements (APA, 2002 as cited in Westefeld et al, 2013). In the case of MAiD, it requires care providers to provide access to medical interventions that may or may not support their own beliefs (Westefeld et al, 2013). Another ethical issue under the principle of social justice is that workers must ensure competence by only practicing within their expertise (Westefeld et al, 2013). Westefeld et al (2013) argued that human service professionals should receive additional training when working with patients that are considering MAiD. Additionally, the authors stated that it is also important that these workers have knowledge on the impact of terminal illness on mental health (Westefeld et al, 2013).

When social workers are working in end-of-life care they must always refer back to the ethical principles that are outlined by the college. Social justice is one of the primary values and functions within social work practice (Morgaine, 2014). The National Association of Social Workers (NASW) recognizes social justice as one of the 6 core values of the profession and involves ensuring that clients receive access to appropriate resources and services (Morgaine, 2014). The British Columbia College of Social Workers (BCCSW) also emphasizes the importance of promoting social justice and advocating for social change within their Code of Ethics (BCCSW, 2009). In working with clients that may be considering MAiD, the principle of social justice will always play a role in determining access to this health care intervention (Morgaine, 2014).

Himchak (2011) explores how the principle of social justice from a social work perspective can address the issues of MAiD among the elderly population. In her research, Himchak explores various forms of social justice and how it is related to assisted dying. She first outlines commutive justice which respects the individual's dignity and worth and that social workers must be mindful of both cultural and ethnic diversity, as well as individual differences (Himchak, 2011). In the case of MAiD, social workers must also have knowledge of the patient's ethnic values and beliefs prior to engaging in any conversations on the topic in order to build an awareness and sensitivity (Himchak, 2011). The role of the social worker is to prevent any exploitation or discrimination of the patient on the basis of their ethnic, cultural, or spiritual beliefs (Himchak, 2011). Himchak also explains that contributive justice is also relevant to MAiD as it promotes family autonomy and shared decision making. For instance, social workers must recognize the value of human relationships and that shared decision making among family members can empower the elderly rather than lead to interdependence. Lastly, the principle of distributive justice is also relevant to MAiD because it recognizes the importance of ensuring the allocation of resources is evaluated from various perspectives so that all individuals have their basic needs met, such as the right to be relieved of suffering and access to MAiD (Himchak, 2011).

Allan and Allan (2020) argue that the opposition of MAiD historically does not go back far because suicide has been practiced to ease human suffering for centuries. Ancient hunter-gatherers, the ancient Greeks and Romans, and even people in the bible practiced suicide to stop unbearable suffering (Allan & Allan, 2020). However, with the growth of Christianity across Europe, suicide and assisted suicide were becoming viewed as taboo topics so authors stopped writing about it (Allan & Allan, 2020). During the 19th century when morphine became available

to use with ether as an aesthetic, the debate over assisted dying was reopened because it was viewed as also being available to use to relive a dying person's suffering (Allan & Allan, 2020). While the debate resulted in many unsuccessful attempts, eventually Switzerland's criminal code was revised to make MAiD possible (Allan & Allan, 2020). Since the law was amended, MAiD has been performed in the country for many years, and eventually made its way to North America. Both Canada and the United States have carefully created policies to ensure that safeguards are put into place so that MAiD is only legally available for those that the practice is designed to assist (Allan & Allan, 2020). The current policy only allows MAiD for those that are living with and suffering from immense physical and/or emotional pain (Allan & Allan, 2020). Proponents of MAiD argue that the intervention can be safely regulated through government intervention (Allan & Allan, 2020).

Ethical Arguments Opposing MAiD

Ethical discussions have raised concerns over both the harms to the patient and to society (Sulmasy et al, 2017). Opponents of MAiD fear that this intervention could become an ethical slippery slope that could result in allowing patients that are not terminally ill to end their lives prematurely (Sulmasy et al, 2017). For example, there is a fear that this law will weaken the taboo against suicide (Sulmasy et al, 2017). Sulmasy et al (2017) argue that MAiD is fundamentally inconsistent with the goals of medicine and could cause moral distress and trauma among health care providers. The authors state that medical ethics establish the duties of physicians and argue that sometimes this occurs to "a greater extent than the law" (Sulmasy et al, 2017 p.577). Physicians have a duty to patients on the basis of beneficence and nonmaleficence, which means to act on the best interest of the patient and to not cause harm, respectively (Sulmasy et al, 2017). Opponents of MAiD emphasize the role of health care providers in

providing comfort care, and that assisting a patient to end their life breaches both of the ethical duties of beneficence and nonmaleficence (Sulmasy et al, 2017). Rather than assisting a patient to end their life, medical ethics support a patient's right to stop any treatment, including life-sustaining treatments (Sulmasy et al, 2017). For instance, when treatment stops death will follow naturally and as a result of the patient's illness (Sulmasy et al, 2017).

Another major ethical concern with MAiD is that the suffering of terminally ill patients may be the result of somatic symptoms such as pain, which can be treated and managed by health care providers (Sulmasy et al, 2017). There are also concerns around whether patients are choosing to complete MAiD because they are suffering from psychological conditions such as depression, which can also be treated (Sulmasy et al, 2017). Patients seeking MAiD may also be struggling with becoming increasingly dependent on nursing staff for their Activities of Daily Living (ADL's), have unresolved conflict, or have feelings of hopelessness (Sulmasy et al, 2017). The authors argued that these symptoms of terminal illness can improve when additional supports are put into place (Sulmasy et al, 2017). Snyder et al (2017) questioned whether it is reasonable to expect medicine to relieve all human suffering. The authors argued that medicine is unable to eliminate death, just as medicine is also unable to eliminate suffering (Snyder et al, 2017). Snyder et al also indicated that MAiD should not be used to relieve pain and suffering because it is not within the scope and goals of medicine.

Law, ethics, and morality are three terms that are often used interchangeably by both health care providers and the general public (Schiller, Pesut, Roussel, & Greig, 2019). Schiller et al (2019) argued that this can lead to confusion regarding the source of the concern, as well as how to best resolve the social issue at play. The authors explained that a major issue with the MAiD law is that it may not coincide with the ethical and moral positions of health care

providers (Schiller et al, 2019). Morals can be described as societal conventions of what is considered right and wrong in human conduct, and they share a "communal consensus" because these views are so widely shared (Schiller et al, 2019 p.2). On the other hand, ethics can be both professional and personal (Schiller et al, 2019). Personal ethics are "highly individualistic" and can vary even among individuals that share the same position, whereas professional ethics are a written code used to guide members in their professional roles and in those relationships (Schiller et al, 2019). The authors explained that it is assumed that a law will reflect morals and the ethics of the majority of its members however this has not been the case with MAiD as many do not support the current law (Schiller et al, 2019). Schiller et al stated that the moral and ethical struggles experienced by health care providers can result in ethical tensions or conflict among other providers, patients, and families. This may be due to the fact that workers are experiencing conflicting feelings between doing what is permissible under the law, and their own personal beliefs.

In working with clients that are considering MAiD, it is imperative to work from an anti-oppressive social work lens. In working from this perspective social workers must use the principle of reflexivity, which requires that social workers consider all of the ways that their own personal values and identity impact the information that they gather and their own understanding of the patients' situation (Burke & Harrison, 2002). Reflexivity requires also social workers to repeatedly consider how social differences and power also impact their work (Burke & Harrison, 2002). Many social workers may find themselves working with a patient that is considering or have already arranged to have a medically assisted death, and this may go against their own personal values and beliefs. Burke and Harrison (2002) urges social workers to consider how their own personal and professional biography may impact their involvement and interactions

with a patient considering MAiD. The authors argue that if they feel that they are not the right social worker for this client due to their own personal beliefs around assisted dying than they should find the patient are more appropriate worker (Burke & Harrison, 2002). Furthermore, it is also imperative to look for ways to minimize the potential for oppressive practice within the next referral.

MAiD vs Euthanasia vs Palliative Sedation

DePergola (2018) argues that there continues to be a misunderstanding around the moral distinctions between MAiD, euthanasia, and palliative sedation. The definition of euthanasia is "a deliberate intervention undertaken with the express intention of ending a life to relieve intractable suffering" and can be either active or passive (Select Committee, 1994, p. 1364 as cited in Allan & Allan, 2020 p. 29). DePergola (2018) explains that the distinction concerns passive vs active forms of euthanasia. The passive form can be described as allowing a patient to stop life-sustaining treatment, whereas active forms refers to the causing of death through receiving a life-shortening treatment (DePergola, 2018). DePergola (2018) defines euthanasia in his research as "a medically contraindicated action or omission that directly and intentionally causes death in the effort to indirectly and unintentionally address, control, and eliminate suffering in full" (p. 95). On the other hand, DePergola defines assisted suicide as the action of a licensed health care provider to provide legally competent patients the means to end their lives, normally through the form of a prescription of a lethal dose of medication. Therefore, the distinction is that rather than withholding or withdrawing treatment or the intentional killing in the case of either form of euthanasia, assisted suicide may not actually involve the health care provider in the actual act of dying itself (DePergola, 2018).

Often patients living with a terminal illness face significant and severe symptoms during the end of life (DePergola, 2018). DePergola (2018) states that in most cases these symptoms can be managed and treated successfully, however in some cases patients' symptoms become uncontrollable and challenging to treat. DePergola explains that refractory symptoms can significantly impact a patient's quality of life and disrupts the ability to ensure a peaceful dying process. ten Have & Weilie (2014) explain that refractory symptoms are symptoms that cannot be controlled without compromising a patient's consciousness. Palliative sedation is then often used as a last approach if a patient suffers from refractory symptoms (DePergola, 2018). The practice of palliative sedation involves the use of sedative medication to reduce consciousness in order to relive patients with refractory symptoms (DePergola, 2018). Palliative sedation does not necessarily require sedation to total levels of unconsciousness and can vary in terms of the level of sedation, duration, and the types of medications used (DePergola, 2018). Deep, continuous palliative sedation that results in unconsciousness is only one form of palliative sedation and is often reserved for patients that have overwhelming symptoms such as massive bleeding, agitation, or pain (DePergola, 2018).

In contrast to MAiD and euthanasia, the practice of palliative sedation is often considered to be morally permissible within both medical ethics and in western society (DePergola, 2018). The researchers explained that the dominant view of palliative sedation is that is not the same as assisted dying. For instance, in palliative sedation the intention is not to end the patient's life, but to relieve unmanageable symptoms (ten Have & Welie, 2014). The intent of the physician is to select drugs that do not have a life-shortening affect (ten Have & Welie, 2014). If palliative sedation is delivered properly then the patient will die after symptoms have been relieved, and any death that occurs as a result of the medications are an adverse outcome (ten Hand & Welie,

2014). Despite these policies, the dominant view of palliative sedation continues to be contested (ten Hand & Weilie, 2014). One of the main arguments cited by the authors is that the term palliative sedation has changed over the years from terminal sedation, deep continuous sedation, total sedation, deep sedation and several others which has confused loved ones which have often cited that they received insufficient information (ten Hand & Weilie, 2014). The other main argument is that there are significant variations within practice, and that policies differ on whether to consult the family or not, which drugs to use, and whether to stop life-sustaining treatments (ten Hand & Weilie, 2014). As a result of these issues many individuals believe that this is a life-ending intervention (ten Hand & Weilie, 2014). The authors argued that these debates reflect the increasing concern from the palliative care community to allow the full incorporation of palliative sedation into palliative care (ten Have & Welie, 2014).

Hanh (2012) also reviews the debate around palliative sedation and its distinction from assisted dying. Hanh argues that while the practice of palliative sedation is widely practiced throughout hospitals around the world, it remains a contentious issue because of its association with assisted suicide. Furthermore, despite being widely practiced, there is no universally accepted definition or practice guidelines (Hanh, 2012). Another major concern is that the same drugs used for MAiD can be used in palliative sedation (Hanh, 2012). Hanh explains that the main difference is that palliative sedation voluntary induces sedation until the patient passes way, rather than used to intentionally cause death and shorten the patient's life. The practice starts with providing the patient with a low dose of a drug and then increasing it until the desired effects are seen, and then continuing administering the drugs until the patient passes away (Hanh, 2012). Hanh states that the ethical principles of autonomy, beneficence, and nonmaleficence also

applies in palliative sedation. Hanh concludes that these ethical principles act as important safeguards within the practice of palliative sedation.

Understanding the various end-of-life care options is crucial to practicing competent social work practice. For instance, having a good understanding of the social work role within the context of palliative sedation. A main issue indicated within the literature is the inconsistency of the definition of palliative sedation, which often leads to confusion among patients and families (ten Hand & Weilie, 2014). The role of the social worker is to ensure that the patient and family understand the process and explore the meaning for the decision with them (Altilio, 2011). Altilio describes the social work role as discussing goals of care, establishing if there is a health care directive, provide a space for questions, facilitate legacy building prior to death, and keeping the support system informed. Altilio (2011) also states that social workers can assist a family by monitoring the outcome of the experience of both the family and of the death itself as it will become part of the legacy of the family. In taking an anti-oppressive approach to practice, social workers must also become aware of their own values, beliefs, and feelings towards palliative sedation (Altilio, 2011).

Social Workers' Role in MAiD/Ethical Issues

While physicians are responsible for providing the means of death during MAiD, social workers can also play a key role as they become involved in assisting patients with their end of life care decisions (Manetta & Wells, 2001). Manetta and Wells (2001) argued that MAiD presents an ethical dilemma for social workers due to a lack of definitive guidelines on behavior, conflicts with personal values, and because current practice guidelines may not have evolved to address current policies. Gaston, Randall, and Kiesel (2018) examined where social workers stand in the assisted dying debate. In their research, the authors discovered that the NASW has

not yet adopted a position concerning end-of-life decisions, but "affirms the right of the individual to determine the level of his or her care" (NASW, 2006 as cited in Gaston et al, 2018). The authors explained that social workers working in palliative care are expected to be familiar with both the legal issues and the complex bioethical considerations (Gaston et al, 2018). The NASW has recently defined the role in only the states where assisted dying has been legalized (Gaston et al, 2018). The NASW stated that the role of the social worker is "ensuring patient choice is heard and honored, creating and upholding policies that protect vulnerable individuals and prevent abuse, facilitating the end-of-life decision-making process, and participating on ethics committees" (NASW, 2015–2017 as cited in Gaston et al, 2018). Social workers are also required to rely on their own understanding of the NASW values and Code of Ethics to guide their practice because the guidelines are often interpretive, which the authors emphasized has been challenging for social workers (Gaston et al, 2018). The authors concluded that knowledge around perceived preparedness to implement assisted dying within their practice, the factors that influence perceived preparedness, as well as the terminology surrounding assisted dying has yet to be studied within social work literature (Gaston et al, 2018).

The Canadian Association of Social Workers (CASW) does not offer practice guidelines specific to MAiD because they are not a regulatory body (CASW, n.d.). It is up to each of the provincial social work colleges to establish their own practice guidelines (CASW, n.d.). The British Columbia College of Social Workers (BCCSW) provides social workers working in end-of-life care with a short article outlining the professional requirements for lawful service of MAiD (BCCSW, 2017). The college states that social workers should play a supportive role in the process (BCCSW, 2017). Furthermore, the college warns that registrants may only perform supportive functions if they:

1. Adhere to the BCCSW standards of practice
2. Comply with the criminal code, workplace policies, and all applicable legislation and
3. Demonstrate adequate knowledge, care, and skill.

The college also outlines that registrants must provide correct and objective information to clients and to never initiate the discussion on MAiD with clients (BCCSW, 2017). It is also up to the social worker to conduct their own independent research on the current legislative changes and resources that are available (BCCSW, 2017). Registrants have the right to refuse to participate in social work services that are directly related to MAiD (BCCSW, 2017). However, it is the responsibility of the social worker to provide a referral to another provider or to inform their supervisor if they chose not to participate in these services (BCCSW, 2017). The paper concludes that social workers must obtain additional training, supervision, and education to gain the knowledge necessary to provide competent social work services (BCCSW, 2017).

There are significant gaps within Canadian research on social workers role in MAiD as it is an emerging and developing area of practice. Rusnack, Schaefer, and Moxley (1988) explain that a social workers role in working with the terminally ill can be described as “orchestrating a safe passage” through a patient’s final stages of life (as cited in Antifaeff, 2019 p. 185). Antifaeff (2019) presents a case study highlighting practice opportunities for social workers throughout the MAiD process. Antifaeff states that reminding yourself of this image can be useful for social workers in providing appropriate psychosocial care, and with patients contemplating or pursing MAiD. In her research, Antifaeff explores how to best support patients in charting their own passage. In working with terminally ill patients, the role of the social worker is to assist patients in defining what a safe passage means to them and providing a space for them to explore their own suffering and gain a sense of clarity over their decision (Antifaeff, 2019). Social workers are

also involved in assisting patients with any “unfinished business”, and any unresolved psychosocial matters (Antifaeff, 2019). In situations where family is involved social workers may facilitate family meetings, or if no family is involved then providing an opportunity to explore the reasons for the absence (Antifaeff, 2019).

Social Workers working with terminally ill patients are often required to complete biopsychosocial assessments as part of their clinical role (Antifaeff, 2019). While social workers assessments are not a requirement within MAiD eligibility, conducting additional assessments are useful to identify any unmet needs that may be contributing to the decision to pursue MAiD (Antifaeff, 2019). The goal of the assessment is to explore the physical, social, emotional, spiritual, and economic reasons that the patient is considering MAiD (Antifaeff, 2019). In completing an assessment early on in the process social workers can explore any identified issues and offer interventions that can meet the needs of the patient (Antifaeff, 2019). Antifaeff explained that the purpose of the assessment is not to try to convince the patient not to go through with MAiD but to ensure that the patients psychosocial needs are met. For example, if the patient has indicated that they feel that they are a burden to their family members then they can encourage a conversation among family members and caregivers (Antifaeff, 2019). The biopsychosocial assessment also explores the patient’s quality of life and how it has contributed to their suffering (Antifaeff, 2019). Antifaeff (2019) emphasized that social workers working with this population require advance skills in communication and rapport building in order to have these difficult conversations with patients. The role of the social worker is to create a safe space for patients to explore their feelings and discussing their fears or distress (Antifaeff, 2019). It is also important that social workers ask patients if they are connected to a religious or spiritual community (Antifaeff, 2019). Antifaeff explains that exploring a patient’s spirituality can give

insight into whether a pursing a MAiD can create any tensions within their own values and beliefs or create an ethical dilemma for them.

Exploring Canadian Physicians Perspectives on Bill C-14

While physicians are not legally required to provide patients with MAiD, the Supreme Court of Canada's ruling on Carter vs. Canada concluded that assisted dying should fall within the scope of care provided by the medical profession in Canada (The College of Family Physicians in Canada, 2015). Recent research on physicians' perspectives on the MAiD found that many physicians feel that the bill does not give clarity to health care professionals that are working with patients suffering from irremediable diseases (Downie & Scallion, 2018). Several factors have made the implementation of MAiD complex such as the vague eligibility that requires physicians to make their own interpretation of the policy (Downie & Scallion, 2018). Downie and Scallion (2018) stated that MAiD legislation uses language that is unclear and has resulted in ongoing confusion among providers. The authors argued that the eligibility criterion that states that "natural death has become reasonably foreseeable" is unfamiliar and that under or over-inclusive interpretations of this criteria has adversely affected patients access to MAiD (Downie & Scallion, 2018). According to the former Minister of Justice Judy Wilson-Raybold the phrase was chosen to provide "maximum flexibility for medical assessment to health care providers, both in terms of the circumstances that led a person to be on a trajectory toward death and in terms of the time during which they can seek medically assisted death" (House of Commons Debates 2016, as cited in (Downie & Scallion, 2018 p.42). The former minister also explained that the they did not put a time frame around reasonable foreseeability to allow practitioners to determine eligibility based on individual circumstances (House of Commons Debates 2016, as cited in (Downie & Scallion, 2018). Downie and Scallion concluded that while

it is appropriate to allow flexibility with respect to the eligibility criteria, it is inappropriate to allow individual practitioners to define terms in the legislation. They also argued that clinical expertise and professional judgement is related to whether an individual has met the criteria, not defining the criteria (Downie & Scallion, 2018). Furthermore, the definition of eligibility is a social judgement that should be determined by the legislature, whereas it is the role of the clinician to decide based on whether the assessment criteria has been met (Downie & Scallion, 2018).

Malpas and Owens (2016) discussed whether MAiD should be part of a physician's role. In their research, they looked at this issue from a medical ethics perspective to examine whether there is a place for MAiD in medicine or not (Malpas & Owens, 2016). The proper role of a physician has been defined as to preserve life, "while providing amelioration of suffering, and respecting the autonomy of patients to refuse or stop life prolonging measures" (Breitbart, 2012 as cited in Malpas & Owens, 2016 p. 298). They argued that allowing MAiD at the end of life when an individual's personal values and priorities are identified could be considered consistent with the physician's role (Malpas & Owens, 2016). Furthermore, medical ethos also states that respecting a patient's autonomy is also consistent with the Doctors role (Malpas & Owens, 2016). While the majority of physician's view MAiD as within their role, those that oppose often cite that the involvement of physicians in making decisions in the practice of assisted suicide are in contrast to what it means to be a physician (Malpas & Owens, 2016). Various medical associations throughout North America and Europe have also stated that it is not compatible with the physician's role as healer and poses many risks to society (Malpas & Owens, 2016). Overall, the authors concluded that there is no strong argument to exclude assisted dying from the role of the physician.

The College of Family Physicians of Canada (2015) discuss the ethical challenges faced by family physicians and argue that adequate ethical deliberation must be made when working with patients that are requesting to complete a MAiD assessment or have the provision. The authors explain that the physician should be aware of their own attitudes, biases, and beliefs around suffering, disability and death prior to having these difficult conversations (The College of Family Physicians of Canada, 2015). The paper highlights the importance of taking into account the uniqueness of each patient and their situation, and to be aware that the values and ethical principles of the patient, family, and physician that may come into conflict (The College of Family Physicians of Canada, 2015). The authors discuss that through reflection and discussion with those involved it is possible to reconcile any conflict (The College of Family Physicians of Canada, 2015). However, if the conflicts are not resolved then the physician should transfer their patient to another physician to ensure that neither the patient or physician compromises the moral integrity of the physician, or the quality of care that the patient receives (The College of Family Physicians of Canada, 2015). Overall, it is important that the physician does continue to support through remaining available to their patients during the final chapter of their lives (The College of Family Physicians of Canada, 2015).

Currently there is currently there is no legal requirement for a social worker to be part of the MAiD assessment or process (BCCSW, 2017). However, since social workers are often required to provide information on MAiD, the CASW advocated for the explicit inclusion of social work for protection in the Criminal Code of Canada on MAiD (CASW, n.d.). The law reads "(5.1) For greater certainty, no social worker, psychologist, psychiatrist, therapist, medical practitioner, nurse practitioner or other health care professional commits an offence if they provide information to a person on the lawful provision of medical assistance in dying" (CASW,

n.d.). CASW acknowledges that they have a dual mission of both promoting the profession and the advance social justice (CASW, 2016). CASW recognizes the important contribution that social workers can make to clients considering a medically assisted death. The issue of physicians not being prepared to provide appropriate counselling to patients seeking MAiD is an important concern acknowledged by CASW. For instance, CASW argues that social workers should play a key role in care teams caring for Canadians considering MAiD because of their unique perspectives (CASW, 2016). Furthermore, they also state that social workers have experience assessing the psychological, social, physical, emotional, economical and spiritual factors that may impact a patient's state of mind (CASW, 2016). CASW also acknowledges that the social workers are a valuable resource to have in a MAiD team because their support goes beyond the client as they can also provide psychosocial support to the families, caregivers, and other professionals involved (CASW, 2016). Overall, social workers can help to fill in the gaps that the physicians may not be able to meet, such as the psychosocial needs of the patients and families.

Palliative Care Access in Canada

Palliative care is an area of health care that supports individuals with life threatening illness and focuses on improving quality of life (Hawley, 2017). The World Health Organization (WHO) also describes palliative care as addressing the physical, psychological, social, and spiritual domains through three components:

1. Provide relief of pain through symptom management.
2. Prioritizes advance care planning and discussion of the patient's goals.
3. Offers a wider support system such as through the offering support for other practical needs in additional to medical supports (World Health Organization, n.d.).

Numerous studies on palliative care programs show that it can improve patient outcomes in many areas such as quality of life, symptom control, and can also reduce caregiver stress and dysfunctional grief (Hawley, 2017). Most often palliative care is provided by multidisciplinary teams that include many health care professionals including physicians, nurses, and social workers (Hawley, 2017). Social workers have an important role within the palliative care team and contribute to research on palliative care. Social workers also play a unique role within the palliative care team because they become advocates for patients and their families and guide them in navigating the challenges and opportunities that present during end-of-life planning (Hawley, 2017). Social workers also provide emotional support to patients and their families, connect them to services, and understand the patients plan of care to assist with addressing their needs (Hawley, 2017).

As the population ages each year it has become increasingly important to assess whether Canadians are having their end of life care needs met. Current research has shown that there are many barriers to receiving access to palliative care in Canada (Hawley, 2017). Hawley (2017) reported that the B.C. Fraser Health Palliative Health Care program cares for a population experiencing approximately 10,000 deaths per year and more than 5,000 referrals to specialized programs. The average length of stay in the program has went from 108 days in 2007 to just 22.5 days in 2016 (Hawley, 2017). Morrison (2018) states that one of the reasons for this trend is that the development of Canada's palliative care program was created organically, rather than strategically, and has mainly been influenced by local resources and practices and recommendations from specialty societies and philanthropic funding. Morrison also looked at the barriers to receiving access to palliative care in Canada and found that that there are four main barriers: lack of public and professional awareness, lack of infrastructure, workforce shortages,

and an insufficient evidence base. Hawley also reports that many specialized palliative care programs also have strict eligibility criteria to access services. Furthermore, many patients are also reluctant to receive palliative care services as there are many misconceptions around palliative care, such as that they need to have end-stage disease (Hawley, 2017). Family physicians and specialists also often fail to refer because they may feel that their skills are no longer required, and that their involvement is no longer needed (Hawley, 2017). In order to address these barriers, Hawley suggests that the key solution is to increase awareness of palliative care and through the "rebranding" of hospice and palliative care services. He argues that rebranding should focus on the benefits of introducing palliative care at much earlier stages of disease management, and to use the funds more responsibility and in a cost-effective manner (Hawley, 2017).

Opponents of MAiD have often cited that the need for MAiD can be eliminated with providing more access to palliative care. Current research has found that many patients do not have appropriate access to palliative care in Canada (Wales et al, 2019). Conlon et al (2019) found that many challenges and barriers exist in providing access to palliative care in northern and rural communities in Canada. In their study, they examined access to palliative care among northern Ontario residents and found that they were less likely to receive palliative care and more likely to receive a form of aggressive end-of-life care, and more likely to die in an acute care hospital than other Ontario residents (Conlon et al, 2019). The authors argued that there is significant inequity among access to palliative care, as well as variation among services offered across the province (Conlon et al, 2019). Furthermore, they highlighted the need for the implementation of a national palliative care strategy that starts much earlier in the disease trajectory (Conlon et al, 2019).

Recent research highlights concern among the Canadian palliative care community on how MAiD can harm patients in rural or remote areas (Collins & Leier, 2017). Collins and Leier (2017) found that only 16-30 percent of Canadians have access to palliative care. One of the main reasons for the lack of access to care is that specialized care programs typically only operate in geographically centralized locations, and is also due to the fact that individual provinces and territories are responsible for delivering health care which also leads to inconsistencies (Collins & Leier, 2017). The authors argue that some of the rationale for MAiD relied on the absence of universal access to palliative care programs in Canada and as a "stop-gap" measure or supplement to palliative care (Collins & Leier, 2017). A major concern among the medical community is that patients should not be forced to use one in the absence of the other (Collins & Leier, 2017). In their research on physicians providing palliative care to rural and remote patients, most physicians reported that they did not feel comfortable providing MAiD (Collins & Leier, 2017). Moreover, the authors questioned whether access to palliative care should be a prerequisite to receiving to MAiD to ensure a realistic choice for palliative care patients (Collins & Leier, 2017). The authors also debate over whether rural physicians could simultaneously embrace a palliative care philosophy and provide MAiD at the same time (Collins & Leier, 2017). Collins and Leier explain that MAiD poses unique challenges to rural and remote physicians that may or may not chose to provide MAiD. They argue that it currently remains unknown if patients chose to have the provision because they have no access to palliative care, and that alternatively if they did have access to the same high quality palliative care would they still chose to complete MAiD (Collins & Leier, 2017). Future research is needed to assess how access to high quality palliative care impacts an individual's decision to end their

lives prematurely (Collins & Leier, 2017). The authors concluded that with high quality palliative care there may no longer be a need for MAiD but that it remains unknown at this time.

Currently there is no national palliative care strategy in Canada and palliative health care programs remain inaccessible for many Canadians (Morrison, 2018). Morrison (2018) argues that one of the barriers to receiving a referral is that many health care professionals lack knowledge and skills in palliative care and are also unaware of how and when to access it. Hawley (2017) explains that it has been shown that providing access to palliative care earlier is associated with more positive outcomes, and that patients that receive palliative care live at least as long as those receiving disease management alone. He argues that modern palliative care should be provided alongside treatments as is it focused on reliving suffering (Morrison, 2018). However, many patients believe that palliative care may shorten life and therefore may not accept a referral to palliative care services (Hawley, 2017). Overall, the concept of providing palliative care alongside disease-targeting approaches has taken several years to become established (Hawley, 2017). Hawley (2017) also states that patients with other life-threatening conditions such as heart or kidney failure have only recently been referred to specialist palliative care programs.

The lack of palliative care services in many areas of the country is a major social justice issue that must be addressed as the population continues to age every year. Frontline palliative social workers often struggle to find appropriate end-of-life care to their clients (Payne, 2010). Payne (2010) argues that social workers have a responsibility to address the inequitable access to palliative care. An older but relevant study looks at how the field of social work can make a valid contribution to addressing these inequities that persist within palliative care access throughout Canada and in the rest of the world (Payne, 2010). The study found that some of the barriers to

accessing palliative care are due to a lack of knowledge from health care providers, a lack of standardized criteria to guide a referral, and that people from socially excluded groups and those without a cancer diagnosis were not likely to be referred quickly enough (Payne, 2010). Payne argues that palliative care programs should be developed to support individuals with a wide range of conditions. He emphasizes that this would reduce inequalities and marginalization among the wider population. Payne also acknowledges that social workers can work to enhance the wider interpersonal, family, and community responses to end-of-life circumstances (Payne, 2010). In taking a social justice approach to practice, social workers can also foster a positive response to reducing inequities in palliative care through prioritizing work with minorities and responding to the economic inequalities the disadvantage many palliative care patients (Payne, 2010).

Does MAiD Fit Within the Hospice/Palliative Care Philosophy?

Allowing MAiD within a hospice setting has been a controversial topic since the law came into effect a few years ago (De Bono, 2017). Under the Canada Health Act, hospices are required to provide MAiD if a patient requests it (Health Canada, 2019). However, some faith-based centers have chosen not to allow patients to complete MAiD at their facility (De Bono, 2017). Faith-based providers in BC have the right to manage and operate according to their religious mission, therefore they do not have to offer services that do not align with their values (De Bono, 2017). In recent headlines, a secular hospice in BC has refused to provide access to MAiD because they argue that it goes against the philosophy of hospice (De Bono, 2017). De Bono (2017) writes that this refusal to offer MAiD within the facility may end up in court as it goes against the Health Authority's policy. Whether MAiD can fit into a hospice philosophy has is currently being debated among researchers.

While various definitions of how to best care for dying patients exist, the goal of hospice and palliative care is to ensure that patients are able to live out their final days as best as possible (DePergola, 2018). The WHO's definition of palliative care also states that it "intends neither to hasten or postpone death" (World Health Organization, 2012 as cited in Materstvedt, 2013 p. 158). What constitutes as a "good death" within palliative care can be described as having a sense of "peacefulness" (DePergola, 2018). A peaceful death is often considered to be one that is in the presence of loved ones, and where a patient has come to an acceptance of death rather than a fear (DePergola, 2018). Currently there is debate within the literature over whether MAiD can also provide patients with a peaceful death.

In his research, Materstvedt (2013) discussed that there are ethical issues when combining palliation and assisted dying. He argues that there are several dangers to patients that can occur when these practices are combined. Combining both palliative care and assisted dying is also known as "integral palliative" care (Materstvedt, 2013 p. 160). Materstvedt stated that he believes that requests for assisted dying maybe an "expression of something else", and that there may be other strategies to assist the patient, such as, providing psychosocial support or treatment for mental health disorders like depression. Another concern is that allowing MAiD may result in the underdevelopment or devaluation of palliative care (Materstvedt, 2013). For instance, Canada is currently dealing with an aging population and it will become more costly when additional comprehensive and health care and treatment will be required, as patients live much longer and therefore may also be ill for longer (Materstvedt, 2013). From an economic perspective, MAiD is significantly less expensive than caring for elderly citizens that may be living with a chronic illness for many years (Materstvedt, 2013). Another issue is that vulnerable persons may feel pressure to ask for MAiD. However, Materstvedt explained that allowing access to MAiD has

not disproportionately impacted vulnerable persons since the law came into effect. Overall, the paper concluded that even if none of these ethical issues become problems within the integral model, problems related to morality still remain (Materstvedt, 2013).

In their study, Inbadas, Carrasaco, and Clark (2019) explore the disagreements between proponents of palliative care and of assisted dying programs. The authors look at the declarations from each side, analyzed them, and categorized them into three distinct dimensions. Firstly, palliative care activists emphasize the fact that assisted dying is not compatible with the goals of medicine (Inbadas et al, 2019). Moreover, the activists state that if there was improved access to palliative care than there would likely not be any more requests for assisted dying (Inbadas et al, 2019). Palliative care activists also argue that assisted dying should be postponed until improvements to the palliative care system have been made (Inbadas et al, 2019). On the other hand, assisted dying activists emphasize issues of social justice such as autonomy and choice (Inbadas et al, 2019). The authors analysis reveals that content from each of the declarations could be categorized as either framing, claiming, or demanding. Framing is related to how the issue is positioned within a body of discourse, the attributes and properties, and position within a wider social context (Inbadas et al, 2019). In the case of assisted suicide versus palliative care, the tone and words vary significantly (Inbadas et al, 2019). However, declarations for both sides cited the importance of human rights in their definition, such as that palliative care access should be available for every individual, and on the other side that assisted dying should also be a basic right and be respected as an end of life care decision (Inbadas et al, 2019). Secondly, claiming was also indicated within the study as the contributions of each side to end of life care (Inbadas et al, 2019). The authors found that claims coming from each side revealed potential consequences such as that palliative care cannot relieve all of human suffering, and that assisted

dying can also have damaging consequences for vulnerable groups that may feel pressure to chose the cheaper or more convenient option (Inbadas et al, 2019). This is a major social justice issue as the more affluent will have more choice due being able to afford better care. The final category cites demanding as the elements that seek action from governments and organizations to advance either palliative care or assisted dying (Inbadas et al, 2019). These areas were focused on education, policy changes, service development, and resources (Inbadas et al, 2019). Demands for better access to palliative care came from both sides, as well as demanding for a change in policies and improved access to resources (Inbadas et al, 2019). Overall, the authors contend that within these declarations from both sides there is a "struggle over the production and mobilization of meanings" (Inbadas et al, 2019 p.583).

Social workers play a major role in providing psychosocial support to patients within the hospice and are often work with patients considering or have planned to have a medically assisted death. Norton and Miller (2012) discussed the role of the hospice social worker in medically assisted deaths and how it fits into social work practice within a hospice facility. The study interviewed 9 hospice social workers in Oregon a few years after law allowing medically assisted dying was implemented (Norton & Miller, 2012). One of the respondents acknowledged the struggle of "serving two masters": the faith-based system and the state (Norton & Miller, 2012 p.254). The participant described that state requires health care workers to discuss assisted dying as option, whereas the faith-based institutions often forbid talking about it (Norton & Miller, 2012). The authors also acknowledged that several of the respondents expressed that the multiple and conflicting and conflicting roles of hospice social workers and the fact that there is not a clear-cut role for social workers as they are not specifically mentioned in the Act (Norton & Miller, 2012). For example, social workers are often required to connect a patient to resources

for an assisted death and to assess a patient's ability to use the law (Norton & Miller, 2012). The authors argued that "this puts hospice social workers in the unique position of balancing the values of the patients, the agencies they serve, and the values they hold as practitioners" (Norton & Miller, 2012 p.259). The study also found that social workers are often forced to balance agency policies that conflict their role as a hospice worker. Overall, the authors concluded that the hospice social worker role will continue to evolve in response to changing policies and values (Norton & Miller, 2012).

Assisted Dying and Disability

There is currently debate around whether MAiD should be extended to include vulnerable populations such as mature minors, individuals living with cognitive impairments or mental illness, or those that have lost the cognitive capacity to consent. While the current Canadian law on MAiD does not specifically restrict access to MAiD on the grounds of mental illness, long-term disability, or individuals living with a curable condition, in practice it would be extremely rare that a provider would find these patients eligible since their death would not be considered reasonably foreseeable (Downie & Scallion, 2018). There is much debate in the literature over whether assisted dying should be available to individuals living with a disability (Riddle, 2017). Riddle (2017) explores the dominant critiques of assisted dying from a disability rights perspective and argues that assisted dying should be permissible for individuals living with a disability. The dominant critiques opposing MAiD for this population are related to the risk and vulnerability of this group (Riddle, 2017). For instance, there is a fear that allowing MAiD to those living with a disability "devalues the lives of people living with a disability" (Riddle, 2017 p. 487). There are also concerns over the potential for abuse or harm of this group (Riddle, 2017). On the other hand, Riddle argues that respect for autonomy and compassion for suffering

are powerful reasons to include this group of individuals. In fact, he feels that having a ban on MAiD for those living with a disability ignores the fact that they are often still capable of making decisions and that they should also have the right to be free from pain and suffering. Riddle emphasizes that denying individuals living with a disability with the right to autonomy on their own health care decisions is damaging for the disabled community. He argues that this policy demeaning and patronizing, and "feeds rather than starves social prejudices" (Riddle, 2017 p. 487). Riddle argues that we should still allow MAiD despite the dominant critiques and that the condition to be terminal should also be dropped from the legislation (Riddle, 2017).

O'Brien (2012) and Scoccia (2010) also discussed that these policies restricting individuals living with a disability to have MAiD have an adverse impact disabled people. O'Brien explained that almost all individuals living with a terminal illness are also a subset of individuals living with a disability. Disability rights advocates support the notion of universal participation that does not discriminate (O'Brien, 2012). O'Brien discussed that the real challenge is not a matter of anti-discrimination or distributive justice, but instead "a question of fundamental values and of the priorities such values entail, and of the character of human dignity and its relationship with dependence" (p.161). Scoccia also writes from disability rights perspective and argued that we should reject this paternalistic view that disabled individuals should be banned from accessing assisted dying for the sake of their own welfare. Furthermore, he explained that there are more violations of autonomy if we were to deny the intervention than allow it (Scoccia, 2010). Overall, he concluded that the current law is consistent with the view that severely disabled people that are not terminally ill can have a good quality of life is provided with an appropriate support network (Scoccia, 2010).

The federal government in Canada has recently proposed changes to the MAiD law including whether it should be extended to allow mature minors or those living with cognitive impairments to have access to MAiD (Government of Canada, 2020). Sullivan and Taylor (2018) explain that opponents argue that allowing vulnerable persons access to MAiD is an "immoral slippery slope" that may have potential for misuse (Sullivan & Taylor, 2018 p.52). One of the dangers cited by patients and their families is that the medical system may view some patients as "disposable and unworthy of care" (Sullivan & Taylor, 2018 p. 52). On the other hand, Reel (2018) argued that while vulnerability should be considered and addressed, a balanced assessment should be conducted on an individual basis. He explained that the overgeneralizations of the current law and the exclusions make it difficult for physicians to provide MAiD (Reel, 2018). Dembo, Schuklenk, and Reggler (2018) also look at whether patients should be eligible for MAiD where mental illness is the sole underlying medical condition and when death is not foreseeable. The authors stated that they also feel that decisions should be made on an individual basis given respect for patient autonomy.

McCormick (2011) states that social work literature on the right to die movement has indicated that social workers are largely supportive of the right to die in the form of passively hastening death, and more than half surveyed from select states support medically assisted dying. Self-determination was listed as the primary reason for the support of this law (McCormick, 2011). McCormick emphasizes that self-determination the major guiding principle within social work practice in health care. In his review of the literature, McCormick found that cultural differences exist among support for the right to die movement. He argues that social workers that oppose assisted dying may find it challenging in trying to balance their own cultural views with those that are in favor of it (McCormick, 2011). However, upon investigation into social work

research on medically assisted dying, there appears to be no significant research conducted on social workers perspectives on this issue. Future research should examine social workers' views on whether social workers take a disability rights perspective on the right to autonomy and self-determination to make their own health care decisions.

An area for future social worker research on assisted dying is the issue on obtaining informed consent. It would be useful to study the questions that are being asked by assessors and examining how they are framed. Additionally, assessing how alternatives are presented to patients seeking MAiD and how the patient understands the alternatives that are provided to them is crucial. Additionally, research should be conducted on how a lack of access to health care, financial, or social support influences an individual living with a disability to pursue MAiD. Currently there is no significant social work research conducted on these issues in Canada.

Advance Directives and MAiD

Another important issue that has been identified in the literature is that individuals are unable to provide advance directives to consent for MAiD if their illness progresses and they no longer meet the criteria of informed consent (Bravo et al, 2017). Alzheimer's disease and other related diseases affect a growing number of adults worldwide (Bravo et al, 2017). While people with these diseases can live for many years with a generally good quality of life, many patients fear living through the advanced stages of these diseases (Bravo et al, 2017). This fear has resulted in many patients seeking advanced requests for MAiD (Bravo et al, 2017). As it currently stands, the law requires that patients have the ability to be cognitively competent at the time of the provision, so many patients either end their lives early or become no longer eligible to complete MAiD (Bravo et al, 2017). Currently the government of Canada is reviewing

whether written requests for MAiD could be made in advance and be accessible even in the event of a loss in capacity (Bravo et al, 2017). Bravo et al (2017) conducted a study to assess whether stakeholders feel that MAiD should be accessible to incompetent patients with dementia. While the study is still ongoing, the authors speculate more stakeholders will support MAiD to be extended to patients with dementia if there is an advance directive put in place (Bravo et al, 2017).

Research into the Netherlands medical assisted dying program reveals that they currently allow advance directives to authorize assisted dying if they can no longer consent to end their lives (Sheldon, 2013). The current law states that patients can make advanced MAiD requests, but they must be voluntary, well-considered, and performed with "due medical care" (Sheldon, 2013 p.5). The law also requires that the patient is suffering "hopelessly and unbearably" (Sheldon, 2013 p.5). The acceptance of advanced requests for patients with dementia has been increasing each year (Sheldon, 2013). Another recent study conducted in the Netherlands found that older patients with advanced directives for medically assisted dying were unlikely to withdraw their advance request (Bolt, Pasman, Deeg, & Onwuteaka, 2016). The study also reports that these requests are the most popular advance requests that are made, but that they often do not result in a medically assisted death (Bolt et al, 2016). Bolt et al (2016) argue that the research supports the current policy as an appropriate end-of-life health care option.

An older but relevant study by Rurup, Onwuteaka-Philipsen, van der Heide, van der Wal, & van der Maas (2005) looked at physician's experiences with advance demented patients with advance directives for MAiD. At the time of this study, there was no reported case of a demented patient receiving MAiD based on an advance directive (Rurup et al, 2005). However, the authors argued that this does not mean that it has not occurred. This study was the first conducted on this

subject and the aim of the study was to estimate the incidence and compliance of advance request for MAiD from demented patients, to gain knowledge and opinions among physicians and their experiences, and to gain more insight into the experiences of these patients and the extent of their suffering and the applicability of advance requests for MAiD (Rurup et al, 2005). The study found that the majority of physicians did not think that advance directives were appropriate for MAiD (Rurup et al, 2005). Furthermore, 75 percent of family members did not support the physician to comply with the directive (Rurup et al, 2005). While most family members did not support MAiD, 90 percent agreed to forgo any life-prolonging treatments (Rurup et al, 2005).

Currently, there are many gaps in the knowledge on providing MAiD with this population as it is a controversial practice among most of the world. Opponents have argued that allowing patients that are no longer able to accept and sign off on the provision is a risky proposition (Bravo et al, 2017). For example, a competent patient can change their mind if they are no longer suffering or want to end their life prematurely (Bravo et al, 2017). Future research priorities should look at the concerns and challenges of providing MAiD through advance directives in countries where it is currently legally permissible. Furthermore, there is very little research on patient or family's experiences of MAiD. Most of the current research is focused on physicians' experiences. Future research should also investigate whether patients are choosing to request MAiD so that they are not a burden to their families and to society.

Social work perspectives on extending access to MAiD to vulnerable populations is absent within the literature. One area that social work research should focus on is the extent to which trauma is a contributing factor to completing an advance directive for MAiD. For example, many patients may fear being in an institution at the end of life and would prefer to end their lives before they end up in residential care. For instance, those that were victims of the

residential schools or those that spent time in hospitals for mental illness and were abused. A potential concern is that individuals would choose to complete MAiD over fears of being vulnerable and potentially abused again.

Recommendations

After reviewing the literature, I found many issues related to current policies and practices around MAiD and have complied a list of recommendations for addressing these problems.

1. Create a mandatory training program that includes a psychosocial component for all care providers involved in assessing or providing the provision.

Upon researching the current professional resources and policy, it was revealed that that is currently there is no mandatory training course for physicians wanting to become providers of MAiD in Canada aside from basic training on the medicine that is used. Ensuring the physicians are trained in how to guide patients through the process, as well as how to support families is needed. Incorporating additional social work perspectives to the training would also be helpful alongside the current medical model that is being used. For example, a social work approach also considers the importance of the nonmedical aspects such as the environment that the provision takes place in and ensuring that what the patient wants is incorporated into the day.

2. Create a more comprehensive monitoring structure for MAiD in Canada.

With the current proposed changes to the MAiD dying legislation to be extended to include vulnerable populations, research evaluating their specific sources of suffering should be examined. For example, whether they are choosing a medically assisted death because they are not receiving appropriate care. A description of the source of suffering would be helpful to understand how oppression and a lack of access to supports that could improve quality of life for individuals living with a disability can impact their decision to contemplate or pursue MAiD.

3. Increase funding for palliative care programs.

It is imperative that all residents have access to palliative care. The Canadian Institute for Health Information (CIHI) published a report on palliative care access across health care settings and found that only 15 percent had received early access to palliative care in the community. The report also found that 62 percent of Canadians that received palliative care took place in an acute care hospital (CIHI, 2018). Recent research estimates that 89 percent of Canadians could benefit from palliative care during their last year of life (CIHI, 2018). There are also numerous benefits of providing access to palliative care much earlier, and that this may prevent a patient from considering an assisted death (Wales et al, 2019). Overall, research on assisted dying contends that improving access to palliative care may reduce the number of patients choosing to end have the provision (Wales et al, 2019).

Discussion

The long road to legalizing MAiD was paved through two pivotal court cases adjudicated through the Supreme Court of Canada. The discussions concerning this issue came from both the Rodriguez v. British Columbia, 1993, and Carter v. Canada, 2015 (Canadian Public Health Association, 2016). In the Rodriguez case, the court based their decision on the concept of

fundamental justice with the judge prohibiting the medically assisted death citing that it was justifiable under Section.1 of the Charter (Canadian Public Health Association, 2016). In citing Section.1 of the Charter of Rights and Freedoms, the court emphasized that the decision was based around the idea of the preservation of life and that it was morally and ethically wrong to allow medically assisted dying (Canadian Public Health Association, 2016). Furthermore, it was argued that the state's role is to protect human life and that lifting the restriction could harm vulnerable individuals citing Section.7 and Section.15 of the charter (Canadian Public Health Association, 2016). In the second case, Carter v. Carter (2015), the Supreme Court of Canada found that the prohibition of assisted dying was no longer justified under Section.1 as there are have been shifts in the way that fundamental justice is viewed (Canadian Public Health Association, 2016). The court recognized that society now largely supports an individual's right to self-determination and to die with dignity (Canadian Public Health Association, 2016). The court found that the prohibition of assisted dying violates Section.7 of the charter because of the rights of individuals for three reasons: the right to life, the right to liberty, and the right to security (Canadian Public Health Association, 2016). The right to life recognizes that a prohibition of assisted dying may result in the individual having to end their life sooner because they may not be able to do so once their symptoms worsen or progress (Canadian Public Health Association, 2016). The right to liberty emphasizes that the state should not interfere with an individual's medical decisions (Canadian Public Health Association, 2016). Lastly, the right to security views that prohibiting medically assisted dying restricts an individual to have control over their own bodily integrity (Canadian Public Health Association, 2016).

The concepts of social justice and health equity are key concepts that are utilized by in public health and social work practices and are fundamental to addressing the social issues related to

MAiD (Canadian Public Health Association, 2016). The principle of social justice recognizes that all individuals should receive equitable access and fair treatment within society (Canadian Public Health Association, 2016). The main argument to legalize MAiD was around the strong belief in self-determination and the rights of individuals to be make their own health care choices. From a social justice perspective, an individual should have the right to decide what happens to their own body. Prior to the legalization of MAiD in Canada there were countless stories reported in the media of Canadians that were diagnosed with incurable illnesses and living with intolerable suffering (Canadian Public Health Association, 2016). These messages highlight the fact that this is a social justice issue and that Canadians should not be forced to suffer from their illnesses or resort to travelling to another country to have a medically assisted death. These stories also emphasize that life can be difficult for individuals that are suffering from incurable or terminal illness, and that relying on assistance for their daily tasks and personal care can be viewed as "an assault on their rights, privacy, dignity and self-esteem" (Canadian Public Health Association, 2016, p.3). In viewing these stories through a social justice lens, it becomes clear that prohibiting MAiD would be conflict with the fundamental principle of social justice (Canadian Public Health Association, 2016).

In the long struggle to legalize MAiD in this country, there were many significant social issues that were not addressed. For example, the issue of inequitable access to social supports and palliative care services in this country. It has been indicated in the literature that there is significant inequity among access to palliative care, as well as variation among services offered across the country (Conlon et al, 2019). Furthermore, research also shows that there are many gaps in social supports and often inadequate services for individuals living with a disability (Sullivan and Taylor, 2018). Walshe, Todd, Caress, and Chew-Graham, (2009) conducted a

literature review on patterns of access to palliative care and found that ethnic minority populations were less likely to receive palliative care. The study concluded that married, younger, and wealthier individuals with a caregiver at home were more likely to be referred to or utilize palliative care services (Walshe et al, 2009). A more recent study conducted in Canada found that while it is considered a human right, access to hospice and palliative care is still not available to everyone that needs to access it (Stajdugar, 2020). In their study, Stajduhar (2020) also reported that those who are privileged are more likely to receive access to it and are also more likely to have family support and a higher socioeconomic status. Stajduhar (2020) also highlighted the fact that individuals facing end of life that are also facing structural inequalities such as poverty and homelessness are not so privileged, and that the current system unintentionally serves to privilege certain groups in need of palliative care (Stajduhar, 2020). This research leads to question whether MAiD should be offered if there are inadequate palliative care services.

Since the legalization of MAiD, there have been several stories reported in the media of individuals that completed MAiD citing a lack of adequate services (Beaudry, 2019). A story hit the news in 2018 about a man who was suffering from a fatal neurological disorder and was denied home care supports to help him live comfortably with his son, and instead was offered MAiD (Smith, 2018). Audio recordings were released by him that show the health care workers pressuring him to consider MAiD, and stated to him that continuing to provide care for him would cost the health care system a significant amount of money (Smith, 2018). Another recent article discusses several stories of Canadians living with severe disabilities that have all ended or considered ending their lives because society failed to provide them with appropriate health, financial, or social supports (Beaudry, 2019). Beaudry (2019) argues that people living with a

disability often find themselves in hopeless conditions because of their social context, rather than the medical condition itself. Those living with a disability are facing oppression because society is failing to provide these individuals with an environment that would "enable rather than disable them" (Beaudry, 2019 para 7). In viewing these cases from a social justice perspective, there should be increased awareness on how MAiD can lead to the abuse of vulnerable populations and unnecessary deaths. More research should look at how oppression impacts the resources that are available and the "resiliency of people contemplating MAiD" (Beaudry, 2019 para 10). Beaudry (2019) points out that many individuals living with a disability have internalized oppression and spend their time fixating on their impairments due to a lack of access to activities that could improve their quality of life. By continuing to ignore these impacts of oppression we are essentially helping these individuals die rather than helping them to live (Beaudry, 2019). Beaudry (2019) concludes that policymakers have a duty to examine whether people are choosing to complete MAiD as a result of the oppression that they face including the ableist or ageist beliefs that believe the lives of disabled individuals matter less than the other "productive members of society" (para 9).

A critical challenge among social workers working in end-of-life is trying to balance the tensions between their interpersonal and interprofessional roles and responsibilities. For instance, working with patients that are considering MAiD may be challenging for social workers that have conflicting beliefs on whether it should be permissible or not. Baines (2011) acknowledges that while it may be challenging for a social worker to address these issues related to MAiD due to their own ethical or moral standpoint, anti-oppressive social work practice requires that workers be open to new ideas that challenge their current feelings. Even if the social worker does not agree with MAiD, it is important that the worker continuously questions their beliefs and

learn more about the social world (Baines, 2011). Moreover, anti-oppressive social work requires that workers build and sustain supportive relationships with service users and their allies, as well as individuals active in social justice movements (Baines, 2011).

A major issue that social workers face in trying to utilize an anti-oppressive approach in social work practice is that social issues are often difficult to address and there are often few resources to combat these injustices (Baines, 2011). Baines (2011) argues that social workers do not have to be involved in policy to make a difference. Frontline social workers can still fight against social injustices by advocating for their clients to receive access to the care and supports that they need. In working from an anti-oppressive approach, social workers must contribute to the greater good rather than "passively accepting injustice and oppression" (Baines, 2011 p.23). In using this approach, social workers must view the problem through a social justice lens which addresses who is benefiting and who is harmed (Baines, 2011). It is also important to address the key players in the issue and who can provide support for a solution or struggle and who are on the same side (Baines, 2011). In the case of MAiD, there are many ethical issues such that this law may harm disadvantaged groups. It is the role of the social worker to ensure that clients are not electing to complete MAiD due to inadequate services or due to coercion.

Conclusion

Recent polls in Canada show most Canadian residents support the current MAiD law (Beuthin et al, 2018). However, the medical profession still has many concerns over the ethical, policy, and practice challenges that the current law has brought forth (Canadian Medical Association, 2017). The CMA has indicated that there are many ethical issues that make it

challenging in practice (Canadian Medical Association, 2017). A report from the CMA in 2017 stated that they support maintaining a balance between patient autonomy to those that are eligible, the protection of vulnerable persons through safeguards that have been put in place, and to continue to create an environment where all practitioners can adhere to their own morals and values. Moreover, many groups including disability rights groups are calling on the government to improve access to MAiD by expanding the criteria to include those living with a disability or cognitive impairment. With the current law to be assessed in 2021, it is essential to address these issues.

While social work literature on practice within end-of-life care is growing, there are still many gaps that need to be addressed as social workers continue to play a major role within interdisciplinary palliative care teams (Antifaeff, 2019). It is integral that social workers receive additional training or education if they are in a role that requires working closely with patients that are being assessed or completing a MAiD. Currently there is a lack of research within the social work literature on the social workers' role in MAiD. Future areas of research within social work should continue to evaluate social workers' role and experiences with MAiD, including how to best support patients and families at this time.

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